State of Rhode Island and Providence Plantations
Department of Mental Health, Retardation and Hospitals

Rules and Regulations for Health and Wellness Standards for Organizations Providing Services or Support to Adults with Developmental Disabilities in Rhode Island

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Donald L. Carcieri, Governor

Department of Mental Health, Retardation and Hospitals

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TABLE OF CONTENTS

Appendices

Appendix A	*Controlled Medication Formulary* Title 21 Food And Drugs Chapter 21-28 Uniform Controlled Substances Act *Article 21-28-2.01 Standards and Schedules* Section 21-28-2.08
Appendix B	*Rules and Regulations Governing the Disposal of Legend Drugs*
Appendix C	RI Nurse Practice Act, Chapter 5-34
Appendix D	Rhode Island Department of Health's *Rules and Regulations for the Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs*
Appendix E	Advisory Committee on Immunization Practices (ACIP)
Appendix F	*Health Care Orientation Curriculum for Direct Support Staff*
Appendix G	Disposal of Controlled Substances Title 21 Food and Drugs Code of Federal Regulations Title 21 Volume 9 Title 21 Food And Drugs Chapter 21-28 Uniform Controlled Substances Act Article 21-28-1.01 Short Title and Definitions Section 21-28-1.01 Title 21 Food And Drugs Chapter 21-28 Uniform Controlled Substances Act Article 21-28-5.01 Powers of Enforcement Personnel Section 21-28-5.07
Appendix H	Specialized Procedures: Training Curriculum and Competency Assessment Checklists
Appendix I	National Fire Protection Association Storage Requirements for Oxygen

PREFACE

The Division of Developmental Disabilities is responsible for the planning, development, and administration of a complete, comprehensive and integrated statewide program of services for adults with developmental disabilities. Individuals receiving services in the developmental disabilities system have the opportunity to choose services that best meet their needs, and support their capacity to live in their homes in the community. The fundamental goal of the Division's long range strategic plan is to support individuals in genuinely taking more personal control over their own lives, and to build and enhance meaningful community membership.

In carrying out this mission, the Division of Developmental Disabilities upholds these principles:

- Each individual is unique; supports and services shall be responsive to the individual and his/her particular situation;
- All of us develop and grow within a community of relationships; supports and services shall be designed to help build relationships;
- Each individual is deserving of respect; the Division strives to meet the highest standards of personal and professional integrity.

Supports and services in the developmental disabilities system are designed to provide a safe environment that allows individuals with developmental disabilities to meet their fullest potential and to be included in the everyday fabric of our society.

The Division of Developmental Disabilities has the responsibility to ensure the basic health and safety of adults with developmental disabilities who are receiving services and supports within the developmental disabilities system. The *Health and Wellness Standards* described herein are the minimum standards of care agencies shall adhere to in the provision of supports and services, and are incorporated by reference into the MHRH *Rules, Regulations, and Standards for Licensing of Agencies Providing Services or Support to Adults with Developmental Disabilities in RI* (RI General Laws Section 40.1-24-1, et seq.).

These Rules and Regulations for *Health and Wellness Standards for Organizations Providing Services or Support to Adults with Developmental Disabilities in Rhode Island* will be implemented in accordance with The Department of Mental Health, Retardation and Hospitals' implementation timeline with full implementation completed on January 1, 2007.

Agencies licensed by the Department of Mental Health, Retardation and Hospitals, ~~and providing supports~~ to provide twenty-four (24) hour residential supports and services to individuals with developmental disabilities have the responsibility to ~~ensure that health care services are provided and documented for all individuals receiving twenty-four (24) hour residential supports and services.~~ assist each individual to identify his/her health care needs and to obtain all necessary and appropriate services to meet those needs. The agency shall document the process used to assist the individual in identifying his/her health care needs, and shall obtain and maintain records from health care providers relative to the provision of such health care services. The nature and scope of the individual's health care needs, the recommendations to meet those needs, and the process for implementing said recommendations ~~and how those needs will be met~~ shall be ~~identified~~ documented in the Individualized Plan (IP).

If an individual is receiving services other than 24 hour residential support, the individual, his/her family as appropriate, and the agency shall determine and agree upon their respective roles in the provision of health care services and supports. The nature and scope of the individual's health care needs, the recommendations to meet those needs, and the process for implementing said recommendations ~~and how those needs will be met~~ shall be ~~identified~~ documented in the Individualized Plan (IP).

These Standards do not address all possible medical conditions as it is understood that medical circumstances will vary for each individual. The nature and scope of an individual's health care needs shall be identified through information gathered during the completion of health care screening and nursing assessments as specified in agency policy and consistent with any pertinent *Standards* described herein.

Note: The *Specialized Procedures* standards and requirements described herein apply only to agencies licensed by the Department of Mental Health, Retardation and Hospitals to provide services and supports to adults with developmental disabilities. These standards do not apply to care provided in nursing homes or hospitals, nor do they apply to care provided by family members.

Acknowledgement

The Division of Developmental Disabilities wishes to acknowledge and thank our colleagues in the Vermont Department of Developmental and Mental Health Services/Division of Developmental Services for their invaluable assistance and generosity in sharing their *Health and Wellness Standards and Guidelines,* and *Regulations Implementing The Developmental Disabilities Act of 1996*, which governs special care procedures performed by specially trained unlicensed personnel. This material has served as a template in the development of the *Health and Wellness Standards* described herein.

Statutory Authority

Authority for issuing these Rules and Regulations may be found in Rhode Island General Laws §40.1-24-1 *et seq.*

SECTION I

DEFINITIONS

1.1 **"*ASSIST AN INDIVIDUAL*"** means to support an individual to the extent necessitated by the individual's degree of disability and with consideration for the individual's right to provide informed consent to or refuse medical treatment, if competent.

1.~~1~~ 2 **"*CONTROLLED SUBSTANCE"*** means a drug, substance or immediate precursor in Schedules I – V of Chapter 21-28, Section 21-28-2.08 of the Rhode Island General Laws, as amended (*Appendix A - Controlled Medication Formulary).*

1.~~2~~ 3 ***"DELEGATION"*** by a Registered Nurse or Licensed Practical Nurse means transferring to competent, appropriately trained Direct Support Staff the responsibility to perform a specific nursing task or procedure in a specific situation.

1.~~3~~ 4 ***"DEPARTMENT"*** means the Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH).

1.~~4~~ 5 **"*DIRECT SUPPORT STAFF"*** means unlicensed ~~agency~~ personnel who have received training in providing supports to adults with developmental disabilities, and who are employed by an agency ~~developmental disabilities provider agencies~~ licensed by the Department of Mental Health, Retardation and Hospitals as a provider of supports and services to adults with developmental disabilities. Direct Support Staff encourage attitudes and behaviors that enhance inclusion, and assist individuals with developmental disabilities to lead self-directed lives and contribute to their communities.

1.~~5~~ 6 ***"LEGEND DRUG"*** means any drug ~~so designated pursuant to the provisions of Chapter 21-31 of the Rhode Island General Laws, as amended, and said drug~~ that is required by law to be labeled: "Caution: Federal Law Prohibits Dispensing Without a Prescription" (*Appendix B - Rules and Regulations Governing the Disposal of Legend Drugs).*

1.~~6~~ 7 ***"LICENSED HEALTH CARE PROVIDER"*** means a duly licensed physician, dentist, certified registered nurse practitioner, podiatrist, or other licensed health care providers authorized by law to prescribe medications.

1.~~7~~ 8 ***"LICENSED NURSE"*** means a Registered Nurse or a Licensed Practical Nurse who holds a current license in good standing to practice nursing in Rhode Island.

1.~~8~~ 9 **"*MEDICATION ERROR"*** means the administration of a medication or treatment other than as prescribed, or the failure to administer a prescribed medication or treatment. By way of example, and not in limitation, a medication error includes:

a. Omission of a dosage(s) or failure to administer
b. Incorrect dosage(s)
c. Incorrect medication(s)
d. Medication(s) given by incorrect administration route
e. Medication(s) given at the incorrect time
f. Medication(s) given to the wrong person
g. Any inappropriate use of medications
h. Failure to follow agency procedures for medication administration
i. Medication or treatment given without an order from a physician or other licensed health care provider.

1.~~9~~ 10 ***"NURSING PROCESS"*** means a systematic, problem-solving approach to meeting the nursing and health care needs of an individual. Nursing interventions take place within the context of the nursing process. The nursing process is comprised of the following essential elements:

a. ***"ASSESSMENT/DATA COLLECTION"*** The Registered Nurse shall conduct a nursing assessment which includes a deliberate and systematic collection of data to determine an individual's current health status, including physical assessment, data analyses, problem identification, and development of a plan of care.

b. ***"NURSING DIAGNOSIS"*** Nursing diagnoses are concise statements of conclusions derived from assessment data collected and include the presenting medical diagnoses and the individual's unique nursing and health care needs. Nursing diagnoses are recorded in a manner that facilitates the nursing plan of care.

c. ***"PLANNING"*** The Registered Nurse shall develop a nursing plan of care based upon the data obtained during the assessment. The elements of the plan of care shall reflect data obtained as part of the individual's initial health care screen as well as subsequent assessments, and shall be congruent with the individual's unique health care needs. The plan of care provides guidance for Direct Support Staff in the provision of health care activities. Nursing plans of care shall be recorded, communicated to others, and revised as necessary according to the agency's written policy and procedure.

d. ***"INTERVENTION"*** The Registered Nurse shall intervene according to the nursing plan of care to implement nursing actions that promote, maintain, or restore wellness and prevent illness. The Registered Nurse shall ensure the implementation of the plan of care and may delegate all or portions of the implementation to the Licensed Practical Nurse or to appropriately trained Direct Support Staff in accordance with the requirements of the delegation process. The Licensed Practical Nurse may assist in the delegation process under the direction of the Registered Nurse. It is recognized that when the Licensed Practical Nurse works in a team relationship with the Registered Nurse, the Licensed Practical Nurse contributes significantly to each aspect of the nursing process. However, final responsibility for the nursing process and its application remains with the Registered Nurse.

e. ***"EVALUATION"*** The Registered Nurse shall evaluate and document the individual's response to the interventions outlined in the plan of care; revise the plan as necessary; and, identify the degree to which the expected outcomes have been achieved.

1.~~10~~ 11 ***"PRACTICAL NURSING"*** Practical Nursing is practiced by Licensed Practical Nurses (L.P.N.'s). It is an integral part of nursing based on a knowledge and skill level commensurate with education. It includes promotion, maintenance, and restoration of health and utilizes standardized procedures leading to predictable outcomes which are in accord with the professional nurse regimen under the direction of a registered nurse. In situations where registered nurses are not employed, the licensed practical nurse functions under the direction of a licensed physician, dentist, podiatrist or other licensed health care providers authorized by law to prescribe. Each L.P.N. is responsible for the nursing care rendered (Rhode Island General Law Chapter 5-34).

1.~~11~~ 12*"PROFESSIONAL NURSING"* Professional Nursing is practiced by Registered Nurses (R.N.'s). The practice of professional nursing is a dynamic process of assessment of an individual's health status, identification of health care needs, determination of health care goals with the individual and/or family participation, and the development of a plan of nursing care to achieve these goals. Nursing actions, including teaching and counseling, are directed toward the promotion, maintenance, and restoration of health and evaluation of the individual's response to nursing actions and the medical regimen of care. The professional nurse provides care and support of individuals and families during periods of wellness and injury, and incorporates where appropriate, the medical plan of care as prescribed by a licensed physician, dentist or podiatrist or other licensed health care providers authorized by law to prescribe. Each R.N. is directly accountable and responsible to the consumer for the nursing care rendered (Rhode Island General Law Chapter 5-34).

Note: Professional Nursing and Practical Nursing as defined in the Rhode Island Nurse Practice Act, Chapter 5-34 of the R.I. General Laws, as amended, entitled "Nurses" (*Appendix C*). "Professional Nurse" is synonymous with "Registered Nurse". "Registered Nurse" is the title referenced herein.

1.~~12~~ 13*"SPECIALIZED CARE PLAN"* means a care plan that is developed for an individual with a developmental disability who requires a specialized procedure as defined herein. The agency shall ensure that a specialized care plan is attached to the Individualized Plan. The specialized care plan is developed by the Registered Nurse, and identifies the specialized procedure(s), and the nurse(s) responsible for conducting the training, determining competence, and providing ongoing monitoring and supervision of the Direct Support Staff.

1.~~13~~ 14*"SPECIALIZED PROCEDURE"* means a procedure that is necessitated by a specific medical need that an individual with a developmental disability would perform but for the individual's disability, or is a procedure that may be delegated provided that, in the determination of the Registered Nurse, the procedure may be safely performed by Direct Support Staff who have successfully completed the required training and have demonstrated competency in performing the task.

1.~~14~~ 15*"SUPERVISION"* means the provision of guidance by a Registered Nurse or Licensed Practical Nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. Total nursing care of an individual remains the responsibility and accountability of the nurse.

Note: "Supervision" definition is based on the definition contained in the Rhode Island Department of Health's *Rules and Regulations for the Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs (R5-34-NUR/ED) (Appendix D).*

SECTION II

2.0 HEALTH CARE POLICIES AND PROCEDURES

2.1 Agencies shall maintain written health care and nursing policies and procedures that address all applicable areas as described herein.

2.2 Agencies providing residential supports and services shall have a policy and procedure outlining nursing support protocols for evening, weekend, and holiday coverage.

2.3 Agencies shall have a policy and procedure outlining the protocol to be followed if the assessment of a Registered Nurse indicates that a specialized procedure cannot be safely delegated. Such policy shall also address the steps that will be taken to ensure that the specialized procedure shall be performed by a Licensed Nurse until such time as it may be safely delegated.

2.4 Agencies shall maintain written policies and procedures providing clear guidance to Direct Support Staff regarding medical emergency response protocols and the utilization of 911. Such policies and procedures shall include the names and contact information for the agency nursing/administrative personnel who shall be notified in the event of a medical emergency situation. Such policies and procedures shall clearly stipulate that securing appropriate emergency treatment shall be the first and immediate priority.

2.0 applies to all Departmental licensed services in the developmental disabilities system.

3.0 EMERGENCY FACT SHEET

3.1 A current emergency fact sheet or other form shall be accessible and available in the agency files and any other relevant location as identified in the agency's policy and procedure. Information required includes, but is not limited to:

a. The individual's name, address, telephone number, and date of birth
b. Social Security number
c. Medicaid number, Medicare number, and/or other insurance information
d. Guardian and/or next of kin's name and telephone number
e. Name and telephone number of the primary licensed health care provider and other relevant health care providers/specialists
f. Medical diagnosis
g. Date of last annual physical
h. Tetanus, TB, and Hepatitis B immunization status
i. List of current medications and dosages
j. List of any known allergies
k. Protocol for emergency treatment, and advance directives (if applicable)
l. Person specific information, e.g., preferred communication method, dietary restrictions
m. Date the information was completed or updated.

3.0 applies to all Departmental licensed services in the developmental disabilities system.

4.0 INCIDENT REPORTS

4.1 Incident reports shall be maintained on serious incidents in accordance with duly promulgated Department of Mental Health, Retardation and Hospitals' regulations. Examples of such incidents include, but are not limited to:

a. An injury that requires medical care or treatment beyond routine first aid
b. Serious or repeated medication errors
c. Abuse, neglect, mistreatment
d. Death.

4.0 applies to all Departmental licensed services in the developmental disabilities system.

5.0 IMMUNIZATIONS

5.1 Influenza, pneumococcal, and other adult vaccination policies and protocols shall be developed and implemented by the agency in accordance with the most current recommendations of The Advisory Committee on Immunization Practices (ACIP) (*Appendix E*) for these vaccinations, and as recommended and ordered by the individual's licensed health care provider.

<u>As the ACIP recommendations may change based on ongoing research, the DDD Office of Health Care will provide agencies with updated information regarding any changes in the recommendations referenced herein</u>.

a. Influenza Vaccination: Annual vaccination as recommended and ordered by the individual's licensed health care provider
b. Pneumococcal Vaccination: Individuals age 65 and older, if not previously vaccinated, and other "at risk" individuals, as recommended and ordered by the individual's licensed health care provider
c. Immunization records are maintained with up to date Tetanus (every 10 years), PPD, and Measles/Mumps/Rubella (MMR date of immunization for anyone born after 1957, where record is available)
d. Hepatitis B vaccine and antibody testing must be offered in accordance with accepted primary care guidelines to all individuals receiving residential supports. Documentation of hepatitis status or date of vaccination must be present in the individual's health care record.

5.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

6.0 MENSES RECORDS

6.1 A record of menses shall be kept for women if determined as a need by the individual's licensed health care provider, or as indicated after an assessment by a Registered Nurse.

6.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

7.0 WEIGHT RECORDS

7.1 A record of monthly weights shall be kept if determined as a need by the individual's licensed health care provider, or as indicated after an assessment by a Registered Nurse.

7.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

8.0 PRESCRIBED NUTRITIONAL DIETS

8.1 Any weight loss/gain or other medically indicated diet shall be prescribed by a nutritionist, or by the individual's licensed health care provider.

8.1.1 The agency shall assist an individual to receive the services of ~~A referral to~~ a nutritionist when such services are ordered by the individual's licensed health care provider. When the individual believes such services would be beneficial but have not been ordered by the licensed health care provider, the agency shall assist the individual to obtain a referral ~~shall be requested~~ from the individual's licensed health care provider. ~~if an individual and/or the clinical staff of an agency believe this may be beneficial.~~

8.1.2 A copy of the prescribed diet shall be maintained in the individual's health care record.

8.1.3 The agency shall assist the individual to follow the prescribed diet ~~shall be implemented~~ as ordered, and shall document the effectiveness ~~documented~~ in the individual's health care record.

8.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

9.0 DEFERRAL OF ROUTINE EXAMINATIONS AND/OR DIAGNOSTIC SCREENING AND TESTING

9.1 The individual's primary licensed health care provider, along with the individual, his/her family as appropriate, the agency's clinical team and licensed nursing staff, may decide that obtaining certain routine examinations or diagnostic screening/testing is too traumatic for the individual and the potential trauma outweighs the benefits.

9.1.1 Documentation of this decision is required to be included in the individual's health care record whenever a routine examination (e.g., gyn exam, dental exam) or diagnostic screening/testing (e.g., lab work, mammography) is deferred.

9.2 If such a decision is made, discussion shall then take place among the agency's clinical team and licensed nursing staff, including the individual, and his/her family as appropriate, regarding a desensitization plan with the goal of allowing testing in the future.

9.2.1 The desensitization plan and the outcomes shall be documented in the individual's health care record.

9.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

10.0 ANNUAL PHYSICAL EXAM

10.1 A physical examination shall be obtained annually, unless otherwise determined by the individual's primary licensed health care provider.

10.2 A copy of the physical exam report or documentation of the exam shall be included in the individual's health care record. At minimum, the documentation shall include:

a. The primary licensed health care provider's name
b. Date and findings of the physical examination
c. Results of lab work, diagnostic and/or cancer screening tests, as ordered
d. Any other recommendations.

10.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

11.0 DENTAL EXAMS

11.1 Dental examinations and cleanings shall be ~~performed~~ obtained as recommended by the American Dental Association, unless otherwise determined by the individual's licensed health care provider.

As the American Dental Association recommendations may change based on ongoing research, the DDD Office of Health Care will provide agencies with updated information regarding any changes in the recommendations referenced herein.

11.2 Documentation of the examination shall be included in the individual's health care record. At minimum, the documentation shall include:

a. The dentist's name
b. Date and findings of the dental exam
c. Any recommendations.

11.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family, as appropriate, and the agency, and as described in the Individualized Plan.

12.0 VISION/EYE HEALTH CARE

12.1 An initial comprehensive eye examination shall be obtained as recommended by the American Academy of Ophthalmology, unless otherwise determined by the individual's licensed health care provider.

As the American Academy of Ophthalmology recommendations may change based on ongoing research, the DDD Office of Health Care will provide agencies with updated information regarding any changes in the recommendations referenced herein.

12.2 Eye/vision exams should be conducted by an ophthalmologist or by an optometrist.

12.2.1 Individuals from the age of puberty to age 40 need to be examined again only if ocular symptoms, visual changes, or injury occur. The exception is for those individuals who are at risk of developing significant eye disease because of risk factors, e.g., chronic disease, family history, etc.

12.3 Eye/vision exams are indicated for individuals age 40 to 64 years;

12.3.1 The frequency of follow up shall be determined by the ophthalmologist or optometrist.

12.4 Individuals age 65 years or older should have an examination every 1-2 years.

12.5 Individuals with diabetes should be examined at minimum every year.

12.6 Glasses shall be provided as prescribed and kept in good repair.

12.6.1 The individual shall receive support to use the glasses as prescribed.

12.7 Documentation of the examination shall be included in the individual's health care record. At minimum, the documentation shall include:

a. The name of the ophthalmologist or optometrist
b. Date and findings of the eye/vision exam
c. Any recommendations.

12.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

13.0 AUDIOLOGY

13.1 Professional audiology examinations shall be obtained, if indicated, by an initial screening or by signs and symptoms of hearing loss, unless otherwise determined by the individual's licensed health care provider.

13.1.1 Such signs and symptoms shall be assessed and documented by a Registered Nurse and an examination scheduled as indicated.

13.2 Documentation of the examination shall be included in the individual's health care record. At minimum, the documentation shall include:

a. The name of the audiologist
b. Date and findings of the audiology exam
c. Any recommendations.

13.3 Hearing aids shall be provided as prescribed and kept in good repair.

13.3.1 The individual shall receive support to use the hearing aid as prescribed.

13.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

14.0 ORTHOPEDIC/PT/OT SERVICES

14.1 An initial orthopedic and/or physical therapy evaluation shall be obtained for individuals with mobility issues, musculo-skeletal or neurological conditions, and/or related types of disease, injury or illness, e.g., spinal disorders, spastic paralysis, etc.

14.1.1 The frequency of follow up examinations shall be determined by the licensed health care provider.

14.2 Documentation of a comprehensive PT and/or OT program to ensure maximum level of function shall be included where indicated by the individual's licensed health care provider.

14.3 Training for Direct Support Staff by a Physical Therapist or Occupational Therapist may be indicated, especially if the individual has medical conditions such as osteoporosis, or has an extensive therapy program.

14.4 Information regarding PT/OT therapy programs shall be included in the Individualized Plan.

14.5 Documentation of the initial, and any subsequent orthopedic/PT/OT consultation(s) and training for staff shall be included in the individual's health care record.

14.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

The PT/OT plan and staff training records shall also be maintained for any other licensed services in the developmental disabilities system when prescribed PT/OT programs are provided.

15.0 NEUROLOGICAL SERVICES AND SEIZURES

15.1 An initial diagnostic evaluation by a neurologist shall be obtained for individuals who have medications prescribed for seizures.

15.1.1 The frequency of follow up evaluations shall be determined by the neurologist, or by the primary licensed health care provider.

15.2 Documentation of the evaluation shall be maintained in the individual's health care record.

15.3 A seizure record shall be maintained in the individual's health care record. The seizure record shall include:

a. Date and time that the seizure occurred
b. Antecedent
c. Duration
d. Type of seizure
e. Post-seizure status.

15.4 Blood levels of seizure medications shall be obtained as determined by the individual's licensed health care provider.

15.4.1 Lab results shall be recorded and maintained in the individual's health care record.

15.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

Seizure records shall also be maintained for any other licensed services in the developmental disabilities system when medications prescribed for seizures are administered.

16.0 LAB AND OTHER DIAGNOSTIC/SCREENING TESTS

16.1 Certain lab tests (blood work) and other diagnostic testing are indicated by diagnosis, age, medications received, and family history.

16.1.1 The types of lab and diagnostic testing and the frequency should be recommended by the primary licensed health care provider after consultation with:

a. The individual, and his/her family as appropriate
b. Agency clinical/nursing staff responsible for assuring that the individual's health care needs are being met.

16.2 Baseline lab testing (e.g., CBC, Blood chemistry, LFT's, FBS, etc.) shall be obtained, unless otherwise indicated by the individual's licensed health care provider. This testing is frequently done as part of a routine annual physical exam.

16.3 Other lab testing is indicated by medications, e.g., seizure, cardiac, psychotropic medications; age; or other risk factors such as family history.

16.3.1 The frequency of testing shall be determined in consultation with the individual's licensed health care provider.

16.4 Documentation of all studies completed and the results shall be included in the individual's health care record.

16.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

17.0 CANCER SCREENING

17.1 The American Cancer Society's (ACS) current recommendations regarding baseline and continuing testing shall be the standards followed, unless otherwise determined by the individual's licensed health care provider.

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As the ACS recommendations may change based on ongoing research, the DDD Office of Health Care will provide agencies with updated information regarding any changes in the recommendations referenced herein.

17.1.1 Colon Cancer Screening: Colon cancer screening should be obtained for men and women 50 years and older. Starting at age 50, both men and women should have:

a. Yearly fecal occult blood test (FOBT) and flexible sigmoidoscopy every five (5) years; or
b. Fecal occult blood test yearly (acceptable but not preferred); or
c. Flexible sigmoidoscopy every five (5) years.
d. Double contrast barium enema every five years; or
e. Colonoscopy every ten (10) years.

Note: Flexible sigmoidoscopy together with fecal occult blood test is preferred when compared to fecal occult blood test or flexible sigmoidoscopy alone.

17.1.2 All positive tests should be followed up with colonoscopy.

17.1.3 Prostate Cancer Screening: Every man 40 years and older should:

a. Have a DRE (digital rectal exam) as part of his annual physical exam
b. In addition to the DRE, the ACS recommends that men 50 years and older have an annual PSA (prostate specific antigen) blood test.

17.1.4 Breast Cancer Screening:

a. Asymptomatic women should have a screening mammogram by age 40
b. Women age 40-49 should have a mammogram every 1-2 years
c. Women age 50 and older should have a mammogram every year
d. In addition, a clinical physical examination of the breast is recommended every 3 years for women 20 to 40 years of age, and every year for those over age 40.

17.1.5 Cervical Cancer Screening:

a. A Pap test should be performed annually with a pelvic examination in women who are, or have been sexually active or who are 18 years or older
b. After three (3) or more consecutive annual examinations with normal findings, the Pap test may be performed less frequently at the discretion of the licensed health care provider.

17.1.6 Skin Cancer:

a. It is recommended that the licensed health care provider examine the individual's skin during the annual physical exam
b. Direct Support Staff shall be instructed to be aware of any changes in the individual's skin or in existing growths, and shall report any changes to the Licensed Nurse
c. All such changes shall be assessed and documented by the Licensed Nurse, and reported to the licensed health care provider.

17.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

18.0 ALTERNATIVE/COMPLEMENTARY THERAPIES

18.1 Alternative and complementary healthcare and medical therapies are those that are not currently an integral part of conventional health care. Conventional healthcare refers to medicine as practiced by a Physician, Nurse Practitioner, or Physician's Assistant.

18.1.1 Alternative and complementary healthcare and medical therapies may include:

a. Chiropractic therapy
b. Homeopathic and herbal medicines
c. Acupuncture
d. Naturopathy
e. Mind/body therapy.

18.2 All therapies need the input of the primary licensed health care provider. Any medications, e.g. herbal or homeopathic, require a written order from the primary licensed health care provider.

18.3 Documentation of the rationale for the therapy, and a written order from the primary licensed health care provider shall be maintained in the individual's health care record.

18.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

A written order from the primary licensed health care provider shall also be maintained for any other licensed services in the developmental disabilities system when alternative or complementary therapies are provided.

19.0 ADAPTIVE AND/OR MEDICAL EQUIPMENT

19.1 Agencies shall assist individuals to obtain ~~ensure that all~~ adaptive and/or medical equipment (e.g., wheelchairs, braces, communication devices, pulse oximetry units, glucose monitors, etc.) ~~is obtained~~ as needed and to maintain such equipment ~~kept~~ in good repair.

19.2 Regular assessment for proper fit, usage, function, and safety shall also be completed.

19.0 applies to all Departmental licensed 24 hour residential services in the developmental disabilities system; and to licensed residential services other than 24 hour as determined and agreed upon by the individual, his/her family as appropriate, and the agency, and as described in the Individualized Plan.

SECTION III

20.0 DELEGATION AND SUPERVISION BY A LICENSED NURSE

20.1 The Licensed Nurse delegating a task or procedure is responsible and accountable for:

a. The supervision of the Direct Support Staff to whom a task or procedure is delegated
b. The quality of the nursing care provided to the individual with developmental disabilities through the process of delegation.

20.2 The Licensed Nurse shall delegate and supervise in accordance with the requirements of Sections 10.1, 10.2, and 10.3 of the RI Department of Health's *Rules and Regulations for the Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs (R5-34-NUR/ED) (Appendix D).*

20.3 Delegation decisions shall be made based on the specific needs of each individual.

20.4 The Licensed Nurse retains accountability for appropriate nursing delegation decisions, therefore if in the nurse's judgment a task or procedure cannot be safely delegated, she/he shall have the authority to make that determination and shall:

a. Document in writing to her/his supervisor the rationale for this decision
b. The steps that have been taken to ensure that the health and safety of the individual with developmental disabilities has not been compromised
c. Specific recommendations as to how the situation may be addressed in order to ensure that the individual receives the supports and services she/he needs

20.4.1 At no time shall an individual with developmental disabilities be placed in a situation in which her/his health and safety needs are not being met.

20.5 The nursing process shall not be delegated in full or in part. The following aspects of the nursing process shall be performed by a Registered Nurse:

a. Conducting a full physical assessment
b. Formulation of nursing diagnoses derived from the assessment data
c. Development of a plan of care
d. Evaluation and documentation of the individual's response to the interventions outlined in the plan of care
e. Revision of the plan as necessary
f. Identification of the degree to which the expected outcomes have been achieved.

20.6 The Registered Nurse shall make an assessment of the individual's specific health care needs prior to delegating a task or procedure.

20.7 The nursing task or procedure shall be one that a reasonable and prudent nurse, utilizing sound nursing judgment, would determine to be appropriate for delegation, <u>having given consideration to at least the following:</u> ~~and include such components as:~~

a. The individual for whom the care is being provided has a stable, chronic condition
b. The treatment outcomes are predictable and do not require Direct Support Staff to exercise nursing judgment

c. The task or procedure may be properly and safely performed by Direct Support Staff without jeopardizing the welfare of the individual with disabilities.

20.8 Direct Support Staff shall have documented skill competencies necessary for the proper performance of the task or procedure and shall perform each delegated task in accordance with instructions given by the delegating nurse.

20.8.1 Prior to delegation, the Registered Nurse shall evaluate the Direct Support Staff person's competency to perform the task or procedure.

Note: Technical assistance in the resolution of nursing delegation issues shall be provided by the DDD Office of Health Care upon request.

20.0 applies to all Departmental licensed services in the developmental disabilities system.

21.0 DOCUMENTATION STANDARDS AND MAINTENANCE OF HEALTH CARE RECORDS

21.1. Health care record information includes, but is not limited to:

a. Licensed health care provider orders and progress notes
b. Continuity of Care Forms
c. Lab and diagnostic testing results
d. Nursing notes
e. Nursing assessments
f. Nursing plans of care
g. Specialized care plans
h. Medications sheets
i. PT/OT/Speech therapy plans/progress notes.

21.2 All health care information shall be documented in blue or black ink.

21.3 ~~All~~ Entries by ~~nurses, other~~ Celinical Pprofessionals, ~~and~~ Direct Support Staff, and any other individuals documenting in the record shall include:

a. Date
b. Time
c. Full signature of the person making the entry
d. Title of the person making the entry.

21.4 Corrections in health care information shall be made by drawing a single line through the incorrect statement/word, writing "omit", initialing above the error, and then entering the correct documentation.

21.5 Late Entry: When a late entry is necessary, the following information shall be documented:

a. Current date and time
b. Documentation information
c. Entry for date and time of occurrence
d. Full signature of the person making the entry.

21.6 Nursing Assessments for individuals who are receiving residential supports shall ~~include~~ be completed in accordance with the following:

21.6.1 At minimum, the Registered Nurse shall complete and document the findings of a nursing assessment on an annual basis.
21.6.2 An assessment shall also be completed and documented whenever there is a significant change in the individual's health status; or, as determined by the Registered Nurse based on the nature and scope of the individual's health care needs.
21.6.3 Nursing Assessments for specialized procedures shall be conducted in accordance with the requirements of 31.2, 37.2, and 37.3 as described herein.

21.7 Nursing Progress Notes for individuals who are receiving residential supports shall ~~include:~~ be completed in accordance with the following:

21.7.1 The Licensed Nurse shall document nursing progress notes or summaries in accordance with the agency's written policy.
21.7.2 The frequency of documentation shall be determined by the nature and scope of the individual's health care needs, and the agency's policy and procedure for documentation.
21.7.3 Appropriate documentation shall be maintained whenever there is a significant change in the individual's health care status.
21.7.4 Nursing Progress Notes for specialized procedures shall be documented in accordance with the requirements of 37.2 and 37.3 as described herein.

21.8 All health care information shall be placed in the individual's record in reverse chronological order.

21.9 The RI Department of Health's *Continuity of Care Form* shall be used for any and all:

a. Medical appointments
b. Referrals to home care agencies
c. Hospitalizations
d. Nursing home admissions
e. Other relevant medical transfers or referrals.

21.10 Health care records shall be kept for a minimum of seven years after the individual leaves the agency.

21.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other Departmental licensed services in the developmental disabilities system when health care and nursing services are provided.

22.0 DIRECT SUPPORT STAFF TRAINING STANDARDS

22.1 Agencies shall have written policies and procedures for ongoing health care in-service training for all Direct Support Staff in accordance with the requirements outlined herein.

22.2 Nursing staff shall delegate only to Direct Support Staff who have received appropriate training and have demonstrated competencies in each area of training.

22.3 Direct Support Staff shall be considered competent upon documentation of satisfactory completion of each training ~~unit~~ module.

22.3.1 Satisfactory completion and documentation of training shall include demonstration as well as knowledge of the delegated task or procedure.

22.0 applies to all Departmental licensed services in the developmental disabilities system.

23.0 TRAINING AND COMPETENCY REQUIREMENTS FOR NEW DIRECT SUPPORT STAFF

23.1 New Direct Support Staff shall participate in the Department of Mental Health, Retardation and Hospitals' ("the Department") standardized and approved *Health Care Orientation Curriculum for Direct Support Staff* (*Appendix F*).

23.1.1 Such training shall be coordinated and provided by the Department or the Department's authorized agent.

23.1.2 New Direct Support Staff shall not be permitted to administer medications until they have successfully completed the Department's standardized and approved Medication Administration Training & Practicum module.

23.2 The Department's standardized and approved *Health Care Orientation Curriculum for Direct Support Staff* includes the following training modules:

a. General Overview of a comprehensive set of medical principles/procedures
b. Standard Precautions/Bloodborne Pathogens /Infection Control/OSHA
c. Wellness/Prevention of Illness
d. Signs and Symptoms of Illness/Injury
e. Basic First Aid/Emergency Care
f. Medication Administration Training & Practicum.

23.3 Competent resource personnel within the health care field may participate as instructors for the *Health Care Orientation Curriculum for Direct Support Staff.* Such personnel may include:

a. Registered Nurses or Licensed Practical Nurses who hold a current Rhode Island license in good standing, and have two (2) or more years of nursing experience
b. Pharmacists who have two (2) or more years of experience in their field may participate as instructors in the medication administration component of the curriculum

23.3.1 All instructors shall have documented experience in teaching adults, and shall provide a resume to the Department or the Department's authorized agent.

23.4 All new Direct Support Staff shall be required to complete Modules A through E of the *Health Care Orientation Curriculum for Direct Support Staff* as described in Section 23.2, prior to being permitted to work alone with an individual.

23.4.1 Documentation of successful completion of Modules A through E of the *Health Care Orientation Curriculum for Direct Support Staff* shall be placed in the employee's personnel file.

23.4.2 A copy of the certificate of completion shall also be placed in a location that is readily accessible to the delegating Licensed Nurse.

a. Such location shall be determined according to the agency's policy.

23.0 applies to all Departmental licensed services in the developmental disabilities system.

24.0 REQUIRED ANNUAL TRAINING

24.1 On an annual basis, all Direct Support Staff shall receive training and demonstrate competency in the following areas:

a. Standard Precautions/Bloodborne Pathogens/Infection Control/OSHA*
b. Wellness/Prevention of Illness*
c. Signs & Symptoms of Illness and Injury*
d. Basic Health Care Treatments
e. Basic First Aid/Emergency Care*
f. Nursing/Health Care Policies and Procedures
g. Nutrition/Food Handling
h. Personal Hygiene
i. Adaptive Equipment, as applicable and relevant to the needs of the individuals supported by the agency
j. Seizure Precautions, as applicable and relevant to the needs of the individuals supported by the agency*
k. Communication and Compliance with Standard Documentation*.

24.2 Training modules denoted by an asterisk (*) shall be conducted using the Department's standardized and approved curriculum as contained in the *Health Care Orientation Curriculum for Direct Support Staff*.

24.2.1 Agencies shall be required to cover all of the material in the curriculum, and may then expand the training to add additional material based on the specific needs of the individuals supported by the agency.

24.3 Competent resource personnel within the health care field may participate as instructors for the Required Annual Training in those areas that reflect their scope of practice. Such personnel may include:

a. Registered Nurses or Licensed Practical Nurses who hold a current Rhode Island license in good standing, and have two (2) or more years of nursing experience
b. Pharmacists; nutritionists/dieticians; physical therapists, occupational therapists, speech and language therapists, and other disciplines as approved by the Department.

24.3.1 Instructors shall have documented experience in teaching adults, and a minimum of two (2) years of experience in their respective fields.

24.3.2 Documentation of the instructor's qualifications shall be maintained in her/his personnel file.

24.3.3 If the instructor is not an employee of the agency, and is engaged by the agency as an independent contractor, the instructor qualifications information shall be maintained in a training consultant file.

24.4 Basic First Aid/Emergency Care shall be taught by a Registered Nurse or other qualified instructor.

24.4.1 For non-nursing personnel, documentation of the instructor's completion of an approved course (e.g., American Red Cross) shall be placed in her/his personnel file.

24.4.2 If the instructor is not an employee of the agency, and is engaged by the agency as an independent contractor, the instructor qualifications information shall be maintained in a training consultant file.

24.5 Documentation of satisfactory completion of the required annual training and competency in all of the areas, as applicable, shall be placed in the Direct Support Staff person's personnel file.

24.5.1 Copies of the competency assessments shall also be placed in a location that is readily accessible to the delegating Licensed Nurse

a. Such location shall be determined according to the agency's policy.

24.6 All Registered Nurses, Licensed Practical Nurses, and Direct Support Staff shall complete an approved course (e.g., American Heart Association; American Red Cross) in Cardio-Pulmonary Resuscitation (CPR).

24.6.1 Documentation of CPR course completion, and a copy of a current certificate or completion card that is renewed, at minimum, every two years shall be maintained in the employee's personnel file.

24.0 applies to all Departmental licensed services in the developmental disabilities system.

25.0 MEDICATION ADMINISTRATION COMPETENCY VERIFICATION FOR EXISTING DIRECT SUPPORT STAFF

25.1 Direct Support Staff who have worked for an agency for at least two (2) years at such time as these Standards are promulgated, and who have received training in medication administration, shall have one (1) year to complete the Department's approved medication administration training curriculum and obtain a certificate of competency, or in the alternative, may receive a certificate of competency qualifying them to continue medication administration if the Registered Nurse documents that the Direct Support Staff person has received medication administration training and has displayed the appropriate competencies to carry out the procedure.

25.2 Documentation of satisfactory completion of the Department's approved medication administration training and a certificate of competency, or a qualifying certificate of competency signed by a Registered Nurse, shall be placed in the employee's personnel file.

25.2.1 A copy of the competency assessment shall also be placed in a location that is readily accessible to the delegating Licensed Nurse.

a. Such location shall be determined according to the agency's policy.

25.3 Direct Support Staff who have worked for a licensed agency for less than two (2) years at such time as these Standards are promulgated, shall have six (6) months to complete the Department's approved medication administration training curriculum and receive a certificate of competency.

25.4 Documentation of satisfactory completion of the Department's approved medication administration training and a certificate of competency shall be placed in the employee's personnel file.

25.4.1 A copy of the competency assessment shall also be placed in a location that is readily accessible to the delegating Licensed Nurse.

a. Such location shall be determined according to the agency's policy.

25.5 All Direct Support Staff shall be required to have a semi-annual medication administration competency assessment completed and documented by a Licensed Nurse within the agency

.

25.5.1 The competency assessment shall be placed in the employee's personnel file.

25.5.2 A copy of the competency assessment shall also be placed in a location that is readily accessible to the delegating Licensed Nurse.

a. Such location shall be determined according to the agency's policy.

25.0 applies to all Departmental licensed services in the developmental disabilities system.

26.0 SPECIALIZED PROCEDURES COMPETENCY VERIFICATION FOR EXISTING DIRECT SUPPORT STAFF

26.1 Direct Support Staff who have worked for an agency for at least two (2) years at such time as these Standards are promulgated, and who have been trained and have performed specialized procedures, may continue to perform such procedures if the Registered Nurse, utilizing the Department's standardized competency assessment form, documents that the Direct Support Staff have displayed the necessary competencies to perform the specialized procedures.

26.2 Documentation of competency for each procedure to be performed, and for whom the procedure may be performed, shall be placed in the employee's personnel file.

26.2.1 A copy of the competency assessment shall also be placed in a location that is readily accessible to the delegating Licensed Nurse.

a. Such location shall be determined according to the agency's policy.

26.3 Direct Support Staff who have worked for an agency for less than two (2) years at such time as these Standards are promulgated shall complete specialized procedures training in accordance with all requirements of section 34.0 as described herein.

26.4 Documentation of satisfactory completion of the training and competency assessment for each procedure to be performed, and for whom the procedures may be performed, shall be placed in the employee's personnel file.

26.4.1 A copy of the competency assessment shall also be placed in a location that is readily accessible to the delegating Licensed Nurse.

a. Such location shall be determined according to the agency's policy.

26.0 applies to all Departmental licensed services in the developmental disabilities system.

27.0 MEDICATION ADMINISTRATION AND TREATMENT STANDARDS

27.1 Medications and treatments shall be stored safely, securely and properly, following the manufacturer recommendations and the agency's written policy.

27.2 Pharmacies dispense medications in containers that meet legal requirements. Medications shall be kept stored in those containers.

27.2.1 An exemption from storage in original containers is permitted if using a pre-poured packaging distribution system (e.g., medi-set).

27.3 A corrected label, corresponding to the medication administration sheet, shall be obtained as directed by the Licensed Nurse, for any medication change orders.

27.4 Medications shall be administered by Direct Support Staff in accordance with the following requirements:

27.4.1 New Direct Support staff shall:

a. Complete the Department's approved *Health Care Orientation Curriculum for Direct Support Staff* medication administration training and practicum in accordance with the requirements of Section 23.1 as described herein
b. Have an assessment of competency completed by a Registered Nurse within the agency
c. Have a certificate of competency signed by the Registered Nurse completing the assessment.

27.4.2 All Direct Support Staff administering medications shall complete the Department's approved *Health Care Orientation Curriculum for Direct Support Staff* medication administration training and/or have competency documented by a Registered Nurse in accordance with the requirements of Section 25.0 as described herein.

27.4.3 Medication administration shall be delegated to Direct Support Staff by a Licensed Nurse in accordance with the requirements of Sections 20.1 and 20.2 as described herein.

27.5 Medication sheets shall be maintained by the agency for all individuals who do not self-administer their medications.

27.6 Medication sheets shall include, at a minimum:

a. Name of the individual to whom the medication is being administered
b. Clear record of the medication(s) name
c. Dosage
d. Frequency
e. Route of administration

f. Date of administration
g. Time of administration
h. Any known medication allergies or other undesirable reaction
i. Any special considerations in taking the medication, e.g., with food, before meals, etc.
j. The initials of the staff person(s) administering the medication.

27.7 The medication sheet shall have a signature sheet of all staff authorized to administer medications ~~and~~ that shall include:

a. The staff person's full signature
b. The initials he/she will be using on the medication sheet.
c. The staff person's name legibly printed.

27.8 A Licensed Nurse shall review the medication sheets, at a minimum, on a monthly basis.

27.9 The Licensed Nurse shall sign and date the medication sheet at the time of the review.

27.10 Medication sheets shall be revised, as necessary, by the Licensed Nurse to reflect any change in medication orders.

27.11 The agency shall have a written policy and procedure describing medication safeguards and support protocols for individuals who self-administer their medications.

27.12 If medication errors or omissions occur, the nature of the error or reason for the omission shall be documented according to the agency's written policy and procedure.

27.13 Storage of medications shall comply with the following requirements:

a. Medications shall be stored in a locked area
b. Medications shall be stored separately from non-medical items
c. Medications shall be stored under proper conditions of temperature, light, humidity, and ventilation
d. Medications requiring refrigeration shall be stored in a locked and secured container within the refrigerator
e. Internal and external medications shall be stored separately.

27.14 Potentially harmful substances (e.g., urine test reagent tablets, cleaning supplies, disinfectants) shall be:

a. Clearly labeled
b. Stored in an area separate and apart from medications.

27.15 All medication and treatment orders shall be reviewed and renewed annually, and as otherwise indicated by the licensed health care provider.

27.16 Any and all medication changes require a new order or prescription. A written order by a licensed health care provider or a copy of the prescription shall be maintained in the individual's health care record.

27.17 The agency shall have a written policy and procedure describing the conditions under which Direct Support Staff may copy a new written medication order from the pharmacy prescription label onto the appropriate documentation form. At minimum, the procedure shall require the following:

a. Identification of and training requirements for agency personnel who shall be permitted to copy the medication order from the pharmacy prescription label onto the appropriate documentation form
b. Safeguards for ensuring that the information has been accurately copied
c. Protocols for verification by a Licensed Nurse within 24 hours of any new orders.

27.18 Documentation of training and a competency assessment shall be placed in the personnel file of any agency employee who shall be permitted to copy new written orders from the pharmacy prescription label onto the appropriate documentation form.

27.18.1 A copy of the competency assessment shall also be placed in a location that is readily accessible to the delegating Licensed Nurse.

a. Such location shall be determined according to the agency's policy.

27.19 The agency's policy and procedure required under 27.17 shall be submitted to the DDD Office of Health Care for approval prior to the implementation of the policy.

27.20 Direct Support Staff shall not be permitted to take telephone or verbal orders from licensed health care providers.

27.20.1 Verbal and/or telephone orders shall be taken and transcribed only by a Licensed Nurse.

27.21 PRN medications prescribed by a licensed health care provider shall include specific parameters and rationale for use.

27.22 All PRN medications shall be documented on medication administration sheets. Documentation shall include:

a. The name of the individual to whom the medication is being administered
b. The name, dosage, and route of the medication
c. The date, time(s) and reason for administration
d. The effect of the medication
e. The initials of the person(s) administering the medication.

27.23 The name and dosages of PRN medications administered for the purpose of behavioral intervention shall be documented according to the written policy and procedures of the agency, and in accordance with all applicable requirements of *Section III - Regulations for Behavioral Interventions*. At minimum, the documentation shall include:

a. A description of the behavior(s)
b. A description of less intrusive interventions implemented prior to administering the medication
c. Documentation of follow-up by licensed nursing staff/supervisory staff.

27.24 Medication checks for anyone taking psychotropic medications shall include direct contact on a regular basis between the individual for whom the medications have been prescribed and the licensed health care provider.

27.24.1 The effectiveness of the medication shall be assessed and documented on a regular basis by the multi-disciplinary clinical team.

27.25 Using a standard instrument, tardive dyskinesia checks shall be performed on a quarterly basis by a licensed nurse or licensed health care provider, for any individual for whom psychotropic medications have been prescribed.

27.25.1 The results of the assessment shall be documented in the individual's health care record.

27.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when medications are administered by agency staff.

28.0 MONITORING OF CONTROLLED MEDICATIONS

28.1 Medications listed in Schedules I, II, III, IV, and V (*Appendix A - Controlled Medication Formulary)* and dispensed by the pharmacy shall be:

a. Appropriately stored
b. Appropriately documented
c. Accurately reconciled.

28.1.1 Schedule I, II, and III medications shall be stored separately from other medications in a securely double locked, substantially constructed cabinet.

28.1.2 Schedule IV and V medications shall be stored in a securely locked, substantially constructed cabinet.

28.2 A controlled medication accountability record shall be completed when receiving a Schedule I, II, III, IV, or V medication. The following information shall be included:

a. Name of the individual for whom the medication is prescribed
b. Name, dosage, and route of medication
c. Dispensing pharmacy
d. Date received from pharmacy
e. Quantity received
f. Name of the staff person receiving delivery of the medication
g. Expiration date.

28.3 Controlled medications that are administered daily shall be counted and reconciled at the end of each shift.

28.4 Controlled medications that are prescribed to be used PRN, or solely as a pre-medication for medical appointments, shall be counted and reconciled at minimum on a monthly basis, and each time that the medication is administered.

28.5 The Direct Support Staff shall comply with the agency's written policy and procedure for reconciliation of controlled medications in independent living arrangements when the individual does not self-administer his/her medications.

28.6 The agency shall maintain signed controlled medication accountability records for all individuals receiving such medications.

28.7 The agency shall have a written policy and procedure describing medication safeguards and support protocols for individuals who self-administer their controlled medications.

28.8 Administration of Controlled Medications: When a controlled medication is administered, the staff person administering the medication shall immediately verify and/or enter all of the following information on the accountability record and the medication sheet:

a. Name of the individual to whom the medication is being administered
b. Name of the medication, dosage, and route of administration
c. Amount used
d. Amount remaining
e. Date and time of administration
f. Signature of the staff person administering the medication
g. Expiration date.

28.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when controlled medications are administered.

29.0 DISPOSAL OF MEDICATIONS

29.1 Disposal of Controlled Substances

29.1.1 Agencies shall have a written policy and procedure for the disposal of damaged, excess and/or expired controlled substances.

29.1.2 The policy and procedure shall outline the agency's protocol for the inventory and disposal of all such controlled medications in accordance with federal Drug Enforcement Administration (DEA) regulations and all other applicable federal, state, and local regulations (*Appendix G*).

29.2 Disposal of All Other Legend Drugs (Non-controlled Substances)

29.2.1 Agencies shall have a written policy and procedure for the disposal of all non-controlled medications.

29.2.2 The policy and procedure shall conform to the requirements outlined in the Department of Health's *"Rules and Regulations Governing the Disposal of Legend Drugs"* (*Appendix B*).

29.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when medications are administered.

30.0 SPECIALIZED PROCEDURES

The term "specialized procedure" means a procedure that is necessitated by a specific medical need that an individual with a developmental disability would perform but for the individual's disability, or is a procedure that may be delegated provided that, in the determination of the Registered Nurse, the procedure may be safely performed by appropriately trained Direct Support Staff.

The purpose for classifying a procedure as a "specialized procedure" is to frame a system for ensuring that Direct Support Staff providing such procedures in home and/or community settings have the appropriate training, competency, and monitoring that is necessary in order to protect the health and safety of the individual for whom the care is being provided.

30.1 Specialized procedures that may be delegated to trained and competent Direct Support Staff include:

30.1.1 Catheter Care: Suprapubic (S/P) tubes and Urethral Catheters: Procedures may include use and care of leg bags/drainage bags, and application of an external catheter (male).

30.1.2 Colostomy/ileostomy care: Procedures may include care of the stoma, application of the appliance, and maintenance of the equipment.

30.1.3 Diabetes Care: Procedures may include administration of oral medications, obtaining and reporting glucometer readings to a Licensed Nurse, and knowledge of dietary requirements.

30.1.4 Enteral Care Procedures: Procedures may include giving medications, hydration, and/or nutrition through a gastrostomy or jejunostomy tube; checking for placement, checking for residual, use, care and maintenance of equipment, proper care of formula, and mouth care.

30.1.5 Respiratory treatments: Procedures may include administering medication using a nebulizer set-up, and care and maintenance of the equipment; using CPAP or BiPAP machines, and maintenance of the equipment; administration of oxygen through the utilization of concentrators, oxygen tanks, and humidification; obtaining and reporting pulse oximetry readings to a Licensed Nurse.

30.0 applies to all Departmental licensed residential services in the developmental disabilities system, and to any other licensed services in the developmental disabilities system when specialized procedures are provided.

31.0 HOW SPECIALIZED PROCEDURES ARE DETERMINED

31.1 The initial determination that an individual may need a procedure requiring specialized skill or training may be made by a Registered Nurse, or by any of the individual's licensed health care providers.

31.2 A Registered Nurse shall complete an assessment of the individual's needs and determine whether a required procedure is a specialized procedure as defined herein.

31.3 A Registered Nurse shall assess the individual requiring a specialized procedure, and make a determination if it may be safely performed by trained and competent Direct Support Staff.

31.3.1 The Registered Nurse shall make this decision based on the criteria described below:

a. The procedure requires skill or training that is not typically possessed by a lay person
b. The individual for whom the procedure will be performed has a stable, chronic condition for which the treatment outcomes are predictable
c. The procedure may be performed safely by Direct Support Staff with appropriate training, supervision, and documented competencies.

31.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other Departmental licensed service when specialized procedures are provided.

32.0 WHO MAY PERFORM A SPECIALIZED PROCEDURE

32.1 A specialized procedure may be performed by Direct Support Staff employed by agencies licensed by the Department of Mental Health, Retardation and Hospitals, who have:

a. Completed specialized training
b. Demonstrated competence
c. Receive ongoing monitoring in accordance with these regulations.

32.2 Agencies shall maintain records for any and all Direct Support Staff performing specialized procedures documenting:

a. The specific training provided
b. The demonstrated competence.

32.3 Competence in performing a specialized procedure is specific to the particular needs, risks, and individual characteristics of the person for whom the procedure will be provided. The fact that a Direct Support Staff person may have been approved to perform a specialized procedure for one individual does not create or imply approval for that Direct Support Staff person to perform similar procedures for another individual.

32.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when specialized procedures are provided.

33.0 SPECIALIZED CARE PLAN

33.1 If it has been determined that an individual requires a specialized procedure, the agency shall ensure that:

a. A specialized care plan is attached to the Individualized Plan
b. A copy of the specialized care plan is placed in the individual's health care record.

33.2 The specialized care plan shall be developed by a Registered Nurse and shall:

a. Identify the specialized procedure(s), and
b. The nurse(s) responsible for conducting the training, determining competency of the Direct Support Staff, and providing monitoring/supervision.

33.3 The specialized care plan shall also include:

a. The frequency with which the Registered Nurse shall monitor the performance of Direct Support Staff providing the specialized procedure
b. Any accommodations in the provision of care that are based on the individual's unique needs
c. Provisions for emergency situations.

33.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when specialized procedures are provided.

34.0 TRAINING REQUIREMENTS FOR SPECIALIZED PROCEDURES

34.1 Qualifications of the Instructor:

34.1.1 Training for specialized procedures shall be provided by Registered Nurses who hold a current Rhode Island license in good standing and have two (2) or more years of nursing experience

a. Documentation of instructor qualifications shall be maintained in the employee's personnel file.

34.2 Timeliness of training:

34.2.1 Appropriate training and documentation of competency shall be completed before any Direct Support Staff person performs a specialized procedure without supervision.

a. Training shall be provided in a timely manner so as not to impede services for an individual.

34.3 Training Curriculum Requirements:

34.3.1 All training in specialized procedures shall be conducted by a Registered Nurse utilizing the Department's standardized and approved *Specialized Procedures: Training Curriculum and Competency Assessment Checklists* manual (*Appendix H).*

34.4 Individual Accommodations:

34.4.1 Individuals with developmental disabilities may have had unique experiences that enhance or obstruct the ability to provide care. In the provision of specialized procedures, a combination of best practice and accommodation of individual characteristics or unique needs shall define the procedures to be utilized for each individual.

a. The Registered Nurse shall identify the specific needs of the individual and document any accommodations necessary in the specialized care plan
b. The Direct Support Staff person shall provide the care in accordance with the instructions outlined by the Registered Nurse.

34.5 Documentation of training:

34.5.1 The agency responsible for the health care needs of the individual is responsible for assuring that a Registered Nurse provides a record of training for any Direct Support Staff person who is carrying out a specialized procedure. The training records shall include the following information:

a. The name and title of the Registered Nurse who provided the training
b. The date(s) the training was provided
c. The name of the Direct Support Staff person who received the training
d. A Competency Assessment Checklist form completed by the Registered Nurse
e. The conditions under which reassessment and/or retraining should occur.

34.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when specialized procedures are provided.

35.0 EMERGENCIES

35.1 The Registered Nurse shall be notified of any changes in the condition of an individual who requires a specialized procedure(s).

35.1.1 Provisions for emergency situations shall be documented in the individual's specialized care plan.

35.2 The agency responsible for the health care needs of the individual shall ensure that, even in emergency situations, specialized procedures shall be performed only by Direct Support Staff trained in accordance with the requirements herein, or by licensed nursing personnel.

35.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when specialized procedures are provided.

36.0 COMPETENCE TO PERFORM SPECIALIZED PROCEDURES

36.1 Competence to perform a specialized procedure is a determination wherein the Direct Support Staff person demonstrates adequate knowledge to perform a task, including the use of equipment, and basic problem solving techniques. Competence includes capability and adequate understanding. Training and supervised practice provide the framework for developing competencies.

36.1.1 Determination of competence:

a. The determination of competence shall be made by a Registered Nurse who holds a current Rhode Island license in good standing and has two (2) or more years of nursing experience.
b. The specialized care plan shall identify the nurse(s) responsible for making this determination.

36.1.2 Supervised practice:

a. A Direct Support Staff person who is working toward but has not yet achieved competency in the performance of a specialized procedure, shall provide such procedures under the supervision of a Registered Nurse.

36.1.3 Competence defined:

a. Competence involves demonstrating safe performance of each step of a specialized procedure and the proper use and maintenance of the equipment.
b. The Direct Support Staff person shall demonstrate that he/she is able to perform the skills and exercise the judgment necessary to carry out the task or procedure.

36.1.4 Documentation of competence:

a. Documentation of training and competency to perform specialized procedures, and for whom they may be performed, shall be placed in the employee's personnel file.
b. A copy of the competency assessment shall also be placed in a location that is readily accessible to the delegating Registered Nurse.
c. Such location shall be determined according to the agency's policy.

36.1.5 Review of competence: The competence of a Direct Support Staff person providing a specialized procedure shall be reviewed and assessed by a Registered Nurse as follows:

a. At minimum, on an annual basis
b. At any time when the Direct Support Staff person's competence is in question
c. At any time when there is a change in the condition of the individual for whom the procedure is being provided.

36.1.6 Review of Competence Documentation: The Registered Nurse completing the competency review and assessment shall document in the Direct Support Staff person's personnel record the following information:

a. The date of the review/assessment
b. The findings of the assessment.

36.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when specialized procedures are provided.

37.0 MONITORING OF SPECIALIZED PROCEDURES

37.1 Ongoing monitoring ensures that the Direct Support Staff person's skills and knowledge remain current. The specialized care plan for the individual for whom the procedure is being performed shall include the following monitoring requirements:

a. The level of intensity of the individual's health care needs
b. The stability of the individual's condition
c. The experience of the Direct Support Staff providing the specialized procedures.

37.1.1 Section 37.1 (a) (b) and (c) shall be the basis for determining the frequency of monitoring necessary to ensure the individual's health and safety.

37.2 In accordance with the agency's written policy and procedure, the Registered Nurse shall be notified of any changes in the condition of an individual who requires specialized procedures.

37.3 The Registered Nurse responsible for the supervision and oversight of the specialized procedure shall conduct a physical assessment of the individual for whom the specialized procedure is being provided no less than twice monthly.

37.3.1 The following information shall be documented as a nursing progress note in the individual's health care record:

a. The date of the assessment
b. The findings of the assessment.

37.4 The Registered Nurse shall assess the status of the individual for whom a specialized procedure is being provided any time there is a change in the individual's condition.

37.4.1 The following information shall be documented as a nursing progress note in the individual's health care record:

a. Nature and scope of the change
b. The date of the assessment
c. The assessment findings.

37.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when specialized procedures are provided.

38.0 OXYGEN (O_2) UTILIZATION AND STORAGE STANDARDS

38.1 The administration of Oxygen is considered a specialized procedure, and is subject to all applicable standards as described herein.

38.1.1 There are specific storage and fire safety requirements related to the use of Oxygen (*Appendix I*) therefore applicable standards are defined herein.

38.2 O_2 therapy in any residential and/or day program setting shall be administered through the utilization of an oxygen concentrator.

38.2.1 Liquid oxygen delivery systems shall not be used in day and/or residential settings.

38.3 During the course of transportation, and/or in community activities, O_2 therapy shall be delivered through the utilization of a portable concentrator or E cylinders that are appropriately secured in a portable transport system.

38.4 Agencies are required by law to maintain one E cylinder oxygen tank for each person receiving O_2 as a back-up in the event of a power failure (the E cylinder must be available even in a home or day site with generator capacity).

38.5 If there is a need to store additional cylinders due to the nature of the O_2 requirements for any individual, a request shall be submitted to the DDD Office of Health Care documenting the following information:

a. The individual's medical condition for which O_2 is required
b. The O_2 orders written by a licensed health care provider
c. The proposed number of tanks to be stored, and,
d. A description of the physical location in which the tanks will be stored.

38.6 Decisions relative to increased tank storage shall be made on a case by case basis after review of the request and documentation.

38.7 E cylinders shall be stored:

a. In an appropriate location that ensures the safety of the individuals in the home and/or day program
b. In a fixed stand or secured to a fixed object
c. Away from direct heat sources.

38.7.1 E cylinders shall not be stored in the individual's bedroom or any communal areas within the home.

38.7.2 E cylinders maintained in day program sites shall not be stored in communal areas.

38.8 Any storage of O_2 must meet the requirements of the National Fire Protection Association's protocols for O_2 storage.

38.9 In extraordinary circumstances in which the individual's need for an O_2 flow rate is greater than the capacity that an oxygen concentrator can deliver, the agency may request a variance to utilize E cylinders or another form of O_2 delivery within the residential/day sites.

38.9.1 Such variance request must be made in writing to the MHRH Office of Standards and Licensure and include documentation of the individual's medical status and O_2 orders.
38.9.2 In the event the variance is granted, any storage of O_2 must meet the requirements of the National Fire Protection Association's protocols for O_2 storage.

38.0 applies to all Departmental licensed residential services in the developmental disabilities system, and any other licensed services in the developmental disabilities system when Oxygen Therapy is administered.

Health Care Website Resources

Alzheimer's Association	www.alz.org
American Cancer Society (ACS)	www.cancer.org
American Diabetes Association	www.diabetes.org
American Heart Association	www.americanheart.org
Centers for Disease Control (CDC)	www.cdc.gov
Centers for Medicare and Medicaid Services (CMS – formerly HCFA)	www.cms.hhs.gov
Developmental Disabilities Nurses Association (DDNA National Organization)	www.ddna.org
National Institutes of Health	www.nih.gov
Occupational Safety & Health Administration (OSHA)	www.osha.gov
RI Department of Health	www.health.state.ri.us
RI Department of Mental Health, Retardation & Hospitals	www.mhrh.state.ri.us
RI State Nurses Association	www.risnarn.org
World Health Organization	www.who.int